



Paresh Dawda

Revalidation – a personal reflection

Background

The review of a doctor's fitness to practice is being increasingly discussed internationally. The Medical Board of Australia has recently announced a desire to explore this issue. The United Kingdom (UK) introduced revalidation for doctors last year. The UK revalidation system is an enhancement of the National Health Service appraisal system that requires doctors to participate in annual appraisals conducted by trained peers. The appraisal process involves four stages: submission of a range of information; a confidential appraisal discussion; a personal development plan; and a post-appraisal sign-off. The criteria that doctors are assessed against are detailed in the General Medical Council's guidelines of Good Medical Practice. Satisfactory participation in the appraisal process over a 5-year cycle is likely to result in a recommendation for successful revalidation.

Objective

To describe the UK revalidation system and to share my personal reflection about the revalidation process.

Discussion

The revalidation process has been beneficial from a personal perspective, but the range of consequences and subsequent support mechanisms need to be considered and addressed.

Keywords

credentialing; clinical competence; medicine/standards

The Medical Board of Australia announced in December 2012 that it had decided to start the conversation on revalidation in Australia.¹ This is said to be a natural progression from the formation of a National Medical Board and influenced by the fact that a number of jurisdictions around the world have introduced a form of revalidation, including Canada, New Zealand and the UK.

This announcement led to a flurry of activity and polls,² and representation made by the Royal Australian College of General Practitioners to the Australian Health Practitioner Regulation Authority.³ As a general practitioner (GP) with a licence to practice in the UK, I have just been revalidated. In this article, I share my personal reflection of the

process and, in doing so, I hope to add value to the debate in Australia.

National Health Service appraisal

In 2002, the UK introduced a national appraisal system for all GPs. Every year since its implementation I have met with a peer GP, who has been trained in conducting appraisals⁴ and is remunerated by the primary care organisation. I collected a portfolio of supporting evidence and submitted it to my appraiser every year. This formed the focus of my annual appraisal meetings. The portfolio was a composite of supporting information to demonstrate the fulfilment of criteria in each of the areas of the General Medical Council's (GMC) Good Medical Practice framework (*Table 1*).⁵ The style of the appraisal varied from appraiser to appraiser, but the main element was a socratic style of questioning with a primary focus on my reflection of my learning based on the submitted evidence.⁶ Questions were often focused on how I had changed my practice, what were the challenges and how might I overcome them. The tangible end product of the process was an agreed commentary of the discussion in each of the areas of Good Medical Practice and a personal development plan with specific, measurable, achievable, realistic and time-bound (SMART) objectives for the forthcoming year, the achievement of which would inform my future appraisal.

Revalidation

Revalidation in the UK serves a dual purpose.⁷ It shows good practice and promotes improvements as well as identifying poorly performing doctors. The revalidation system is based on an enhancement of the appraisal system and after a number of iterations, the Royal College of General Practitioners (RCGP) has produced guidance for GPs on revalidation.⁸ An appointed Responsible Officer makes a recommendation to the GMC on revalidation of each doctor and is almost entirely informed by the appraisal process.⁹

Key elements of the supporting information for revalidation¹⁰ that demonstrate whether the requirements of Good Medical Practice have been met include:

- a reflective continuing professional development log
- feedback on the doctor's practice
- quality improvement activity to include clinical audit and significant event auditing
- a range of other materials, including personal details, scope of work, record of annual appraisals, personal development plans and declarations of probity and health.

Information for validation

I've diligently kept a log of all my learning using a national web-based system. This has included not only formal courses attended but, more importantly, knowledge I've acquired through exploring questions raised by clinical encounters, such as researching a condition that a patient presented at my practice. Where possible, I tried to collect evidence of changes to my practice as a result of my learning, and this allowed me to double my credits.¹¹ This ongoing recording of information has meant that achieving the mandatory 50 learning credits a year has been straightforward and easily achievable.

I've had a role in providing quality improvement training across the National Health Service (NHS) and therefore producing the evidence in quality improvement was not onerous, although for some GPs it may be. At least one full clinical audit cycle is mandatory; however, other materials such as prescribing and referral review may also be used as well. Additionally, an average of two significant event audits a year need to

be documented and must demonstrate, through analysis, areas for improvement, reflection and implementation of change.

Feedback on practice includes a patient survey, a colleague survey and a review of complaints and compliments. I've conducted each type of survey and kept a log of complaints, compliments and plaudits received. The colleague survey included other GPs in the practice, approved GP trainers in the wider community and a number of non-clinical staff. The patient survey was of patients who actually consulted with me, rather than a practice-based survey. A challenge with the surveys was to get the prescribed response rate from patients and colleagues. A number of survey instruments have been identified and while it is not mandatory to use these instruments, it is a requirement that the survey is focused on the GP, their work and the quality of their care, and is gathered objectively and confidentially. Again the underlying theme is to reflect on the results of the survey, identify areas for improvement and then review.

Reflections

The opportunity to meet with a professional peer and confidentially share my personal development, my areas of strength, but also my areas for improvement, and having a facilitated conversation to help me plan my own development, has been tremendously positive. However, the process does require discipline, particularly to record and, more importantly, to reflect on my learning and how it has changed my practice. There is indeed an additional time cost. The appraisal meeting was usually 3 hours in length, and on average it took another 5 or 6 hours to collate the evidence and complete

the forms, which is in keeping with an average of 9 hours found in the revalidation pilots.¹² In my experience, this investment of time has been worthwhile and I have particularly valued the formative element of the process. It has been motivating to receive positive and also constructive feedback from my appraiser. Not only has the process focused on keeping my technical knowledge up to date but, more importantly, it has put a high value on demonstrating the application of that knowledge and on a range of non-technical skills that are equally critical to patient safety. Receiving the letter from the GMC advising me of successful revalidation, the summative element, brought a sense of achievement similar to that when I passed my final medical student examinations or the College's membership exams over 15 years ago. It's immensely reassuring to be able to demonstrate to my patients that peers have validated my skills as a GP.

But what if that GMC letter had contained an adverse recommendation? The alternative outcomes to successful revalidation are a recommendation to defer or a notification of non-engagement. What would that mean for my career? What retraining would I need? Would I be able to work whilst retraining? How would I support my family? What would be the cost of retraining? And would I ever be able to work as a doctor again? I am sure these questions have been considered by the regulators and that there are processes and support mechanisms in place. However, it is only once the system embeds itself and the range of outcomes from the revalidation process are seen and evaluated, that reassurances on these questions to individual doctors will be possible. Such reassurance is necessary if the

Table 1. Good medical practice framework⁵

Domain 1 – Knowledge, skills and performance	Domain 2 – Safety and quality	Domain 3 – Communication, partnership and teamwork	Domain 4 – Maintaining trust
<ul style="list-style-type: none"> • Develop and maintain your professional performance • Apply knowledge and experience to practice • Record your work clearly, accurately and legibly 	<ul style="list-style-type: none"> • Contribute to and comply with systems to protect patients • Respond to risks to safety • Protect patients and colleagues from any risk posed by your health 	<ul style="list-style-type: none"> • Communicate effectively • Work constructively with colleagues to maintain or improve patient care • Teaching, training, supporting and assessing • Continuity and co-ordination of care • Establish and maintain partnerships with patients 	<ul style="list-style-type: none"> • Show respect for patients • Treat patients and colleagues fairly and without discrimination • Act with honesty and integrity

medical profession is to fully embrace revalidation and its goals, even though very few doctors are expected to be unsuccessful in revalidation.¹³ In my opinion as revalidation is implemented, those doctors with insight into their own lack of fitness to practice may decide not to pursue revalidation and retire from practice. The multifaceted approach will identify poorly performing doctors, and in the long run the formative nature will provide opportunity for interventions to prevent a doctor from becoming unfit to practice. If this formative benefit is realised then I sense that the cost–benefit pendulum will swing in favour of overall benefit.

The International Association of Medical Regulatory Authorities defines revalidation as “the process by which doctors have to regularly show that they are up to date, and fit to practise medicine. This will mean that they are able to keep their licence to practise”¹⁴ and I am delighted to have successfully been through such a process.

My experience has been positive, and ensuring fitness to practice via a revalidation process helps to assure patient safety. However, revalidation is focused on the individual rather than the system in which that individual works. Therefore, there needs to be an equal, if not greater, emphasis on assessment of the wider system.

The process of revalidation needs to focus equally on valuing the impact of technical knowledge and softer non-technical skills, because as individuals we practise and work in teams, and our interpersonal skills with our patients and colleagues are hallmarks of quality. Patients have explicitly expressed the need for revalidation to consider softer skills and not be so onerous that it detracts from time spent with patients.¹⁵ There is a cost to revalidation in terms of time and money, and inevitably there will be doctors who are not successful. The process, if it occurs in Australia, needs to be mindful of all these factors.

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